FOR OHF USE

LL I

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045138

Facility Name: COTILLION RIDGE NURSING HOME

Address: 600 EAST ROBINWOOD DR. (Number) ROBINSON (City) 62454 (Zip Code)

County: CRAWFORD

Telephone Number: (618) 544-3192 **Fax #** ( )

IDPA ID Number: 371402726

Date of Initial License for Current Owners: 11/01/00

Type of Ownership:

	VOLUNTARY,NON-PROFIT	XX	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		XX	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name CRAIG L. ATER **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) CRAIG L. ATER
(Title) TREASURER

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	38	Skilled (SNF)	38	13,870	1
2		Skilled Pediatric (SNF/PED)			2
3	35	Intermediate (ICF)	35	12,775	3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0		5
6		ICF/DD 16 or Less			6
7	73	TOTALS	73	26,645	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,777	9,115	2,082	24,974	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	13,777	9,115	2,082	24,974	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 93.73%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? _____

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 2000

J. Was the facility purchased or leased after January 1, 1978?
YES [XX] Date 2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 2,082

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Print Preview

	G/L	RECAP CENSUS	DIFF
PP	9165	9165	0
IPA	13853	13853	0
medicare	2082	2082	0
	25100	25100	

IPA BEDHOLDS	76
PP BEDHOLDS	50
PP CONVERS	0

Facility Name & ID Number COTILLION RIDGE NURSING HOMI # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	107,544	8,378	0	115,922		115,922	0	115,922			1
2	Food Purchase		93,549		93,549		93,549	(469)	93,080			2
3	Housekeeping	49,002	14,694		63,696		63,696	0	63,696			3
4	Laundry	29,823	10,136		39,959		39,959	0	39,959			4
5	Heat and Other Utilities			51,213	51,213		51,213	0	51,213			5
6	Maintenance	43,128	22,562	19,695	85,385		85,385	0	85,385			6
7	Other (specify):*							0				7
8	TOTAL General Services	229,497	149,319	70,908	449,724		449,724	(469)	449,255			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000	0	18,000			9
10	Nursing and Medical Records	709,555	47,680	8,722	765,957		765,957	0	765,957			10
10a	Therapy		44,985	97,068	142,053	(50,736)	91,317	0	91,317			10a
11	Activities	21,446	1,565	0	23,011		23,011	0	23,011			11
12	Social Services	33,404	971	4,563	38,938		38,938	0	38,938			12
13	Nurse Aide Training	11	0		11		11	0	11			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16		764,416	95,201	128,353	987,970	(50,736)	937,234		937,234			16
	C. General Administration											
17	Administrative	65,009			65,009		65,009	0	65,009			17
18	Directors Fees							0				18
19	Professional Services			174,517	174,517		174,517	0	174,517			19
20	Dues, Fees, Subscriptions & Promotions			57,574	57,574	(36,135)	21,439	(12,527)	8,912			20
21	Clerical & General Office Expense	95,084	10,452	8,024	113,560		113,560	0	113,560			21
22	Employee Benefits & Payroll Taxes			154,576	154,576		154,576	0	154,576			22
23	Inservice Training & Education			1,273	1,273		1,273	0	1,273			23
24	Travel and Seminar			8,768	8,768		8,768	(6,769)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			35,938	35,938		35,938	0	35,938			26
27	Other (specify):*			13,687	13,687		13,687	(13,687)				27
28	TOTAL General Administration	160,093	10,452	454,357	624,902	(36,135)	588,767	(32,983)	555,784			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,154,006	254,972	653,618	2,062,596	(86,871)	1,975,725	(33,452)	1,942,273			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

Facility Name & ID Number COTILLION RIDGE NURSING HOMI # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			15,001	15,001		15,001	0	15,001			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			64,717	64,717		64,717	(1,387)	63,330			32
33	Real Estate Taxes			16,294	16,294		16,294	0	16,294			33
34	Rent-Facility & Grounds			246,500	246,500		246,500	0	246,500			34
35	Rent-Equipment & Vehicles			16,896	16,896		16,896	1,595	18,491			35
36	Other (specify):*			14,064	14,064		14,064	(14,064)				36
37	TOTAL Ownership			373,472	373,472		373,472	(13,856)	359,616			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					50,736	50,736	0	50,736			39
40	Barber and Beauty Shops	0	0	16,401	16,401		16,401	0	16,401			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					36,135	36,135	0	36,135			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers			16,401	16,401	86,871	103,272		103,272			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,154,006	254,972	1,043,491	2,452,469	0	2,452,469	(47,308)	2,405,161			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	1,595	35		5
6	Rented Facility Space	0	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	0	30		9
10	Interest and Other Investment Income	(1,387)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(469)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	0	33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(748)	20		17
18	Fines and Penalties				18
19	Entertainment	(6,769)	24		19
20	Contributions	(475)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	0	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,212)	27		24
25	Fund Raising, Advertising and Promotional	(11,779)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Goodwill	(14,064)	36		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (47,308)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (47,308)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS — **Page 5A**

Facility Name COTILLION RIDGE NURSING HOME

IDPH 0005128

Report Period Beginning: 1/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.			**Line 1**	0
1	**Day Care**	0	0	**Line 2**	(482)
2	**Other Care for Outpatients**	0	0	**Line 3**	0
3	**Governmental Sponsored Special Programs**	0	0	**Line 4**	0
4	**Non-Patient Meals**	0	0	**Line 5**	0
5	**Telephone, TV & Radio in Resident Rooms**	1,595	35	**Line 6**	0
6	**Rented Facility Space**	0	34	**Line 7**	0
7	**Sale of Supplies to Non-Patients**	0		**Line 8**	(469)
8	**Laundry for Non-Patients**	0		**Line 9**	0
9	**Non-Straightline Depreciation**	0	30	**Line 10**	0
10	**Interest and Other Investment Income**	(1,387)	32	**Line 10a**	0
11	**Discounts, Allowances, Rebates & Refunds**	0		**Line 11**	0
12	**Non-Working Officer's or Owner's Salary**	0		**Line 12**	0
13	**Sales Tax**	(469)	2	**Line 13**	0
14	**Non-Care Related Interest**	0	32	**Line 14**	0
15	**Non-Care Related Owner's Transactions**	0	33	**Line 15**	0
16	**Personal Expenses (Including Transportation)**	0	24	**Line 16**	0
17	**Non-Care Related Fees**	(748)	20	**Line 17**	0
18	**Fines and Penalties**	0		**Line 18**	0
19	**Entertainment**	(6,769)	24	**Line 19**	0
20	**Contributions**	(475)	27	**Line 20**	(12,512)
21	**Owner or Key-Man Insurance**	0		**Line 21**	0
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 22**	0
23	**Malpractice Insurance for Individuals**	0		**Line 23**	0
24	**Bad Debt**	(11,212)	27	**Line 24**	(6,760)
25	**Fund Raising, Advertising and Promotional**	(11,779)	20	**Line 25**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 26**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 27**	(13,437)
28	**Yellow Page Advertising**	0	0	**Line 28**	(12,968)
29	**Non-Paid Workers**	0	0	**Line 29**	(13,437)
30	**Donated Goods**	0	0	**Line 30**	0
31	**Amortization Expense**	0	0	**Line 31**	0
32		(14,064)	36	**Line 32**	(1,387)
33				**Line 33**	0
34				**Line 34**	0
35				**Line 35**	1,595
36				**Line 36**	(14,064)
37				**Line 37**	(13,836)
38				**Line 38**	0
39				**Line 39**	0
40				**Line 40**	0
41				**Line 41**	0
42				**Line 42**	0
43				**Line 43**	0
44				**Line 44**	0
45				**Line 45**	(47,109)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(469)	0	0	0	0	0	0	0	0	0	0	(469)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(469)	0	0	0	0	0	0	0	0	0	0	(469)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(12,527)	0	0	0	0	0	0	0	0	0	0	(12,527)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6,769)	0	0	0	0	0	0	0	0	0	0	(6,769)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(13,687)	0	0	0	0	0	0	0	0	0	0	(13,687)	27
28	**TOTAL General Administration**	(32,983)	0	0	0	0	0	0	0	0	0	0	(32,983)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(33,452)	0	0	0	0	0	0	0	0	0	0	(33,452)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,387)	0	0	0	0	0	0	0	0	0	0	(1,387)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	1,595	0	0	0	0	0	0	0	0	0	0	1,595	35
36	Other (specify):*	(14,064)	0	0	0	0	0	0	0	0	0	0	(14,064)	36
37	TOTAL Ownership	(13,856)	0	0	0	0	0	0	0	0	0	0	(13,856)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(47,308)	0	0	0	0	0	0	0	0	0	0	(47,308)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe COTILLION RIDGE NURSING HOMI # 0045238 Report Period Beginning 1/01/01 Ending 12/31/01

Show Pgs 6A thru 6E | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger: Item	4 Amount	5 Cost to Related Organization: Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		$		$	$		1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$			$	$ *	14

Sum_6

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Facility Name & ID Number COTILLION RIDGE NURSING HOM # 0045138 Report Period Beginnin 1/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JOSEPH WARNER			0.20	0				$ 0		1
2	CHERL LOWNEY			0.20	0				0		2
3	STEVE WANNEMACHER			0.20	0				0		3
4	CONNIE HOSELTON			0.20	0				0		4
5	CRAIG ATER			0.20	0				0		5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT C

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number COTILLION RIDGE NURSING HOMI # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Alpha Community Bank		xx	Purchase Operations & Equ	$12,808.00	11/1/00	$ 1,055,000	$ 909,632	11/1/05	variable	$ 63,826	1
2	Loan Fee Amort										891	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$12,808.00		$ 1,055,000	$ 909,632			$ 64,717	9
	B. Non-Facility Related*											
10	Interest Income										(1,387)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,055,000	$ 909,632			$ 63,330	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	14,814	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	15,174	2
3. Under or (over) accrual (line 2 minus line 1).	$	360	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	15,934	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	16,294	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COTILLION RIDGE NURSING HOME COUNTY

FACILITY IDPH LICENSE NUMBE 0045138

CONTACT PERSON REGARDING THIS REP(CRAIG L. ATER

TELEPHONE 309-823-7135 FAX # ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the port of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any porti the nursing home property which is vacant, rented to other organizations, or used for purposes other than long te care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05427033042000	COTILLION RIDGE NURSIN	$ 14,979	$ 14,979
2.	05427033041000		$ 196	$ 196
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 15,175	$ 15,175

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not c used for nursing home services? YES xx NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Numb COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land			$ 0	1
2				0	2
3	TOTALS			$	3

Print Preview

Facility Name & ID Number COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	73				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Acquisition of Building Improvements from prior Operator			2001	154,177						9
10											10
11	Dinning Room/Day Room Addition---Outside Contractor			2001	164,291						11
12	Dinning Room/Day Room Addition---Design			2001	50,288						12
13	Dinning Room/Day Room Addition---Wallcoverings			2001	9,670						13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation										34
35	Book Depreciation					10,278		10,278		11,992	35
36											36

*Total beds on this schedule must agree with page 2. See Page 12A, Line 70 for Total

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

0 Page 12B
0 Page 12C
0 Page 12D
0 Page 12E
0 Page 12F
0 Page 12G
0 Page 12H
0 Page 12I

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Numbe COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37									37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 378,426	$ 10,278		$ 10,278	$ 0	$ 11,992	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Numbe COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 378,426	$ 10,278		$ 10,278	$	$ 11,992	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 378,426	$ 10,278		$ 10,278	$ 0	$ 11,992	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Numbe COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 378,426	$ 10,278		$ 10,278	$	$ 11,992	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 378,426	$ 10,278		$ 10,278	$ 0	$ 11,992	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 378,426	$ 10,278		$ 10,278	$	$ 11,992	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 378,426	$ 10,278		$ 10,278	$ 0	$ 11,992	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

To Print this page onl

Facility Name & ID Numbe COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

Hold down Control Key and hit t

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 378,426	$ 10,278		$ 10,278	$	$ 11,992	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 378,426	$ 10,278		$ 10,278	$ 0	$ 11,992	34

**Improvement type must be detailed in order for the cost report to be considered complete.

y

Facility Name & ID Numbe COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 378,426	$ 10,278		$ 10,278	$	$ 11,992	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 378,426	$ 10,278		$ 10,278	$ 0	$ 11,992	34

**Improvement type must be detailed in order for the cost report to be considered complete.

To Print this page onl

Hold down Control Key and hit w

y

To Print this page onl

Facility Name & ID Numbe COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

Hold down Control Key and hit k

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 378,426	$ 10,278		$ 10,278	$	$ 11,992	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 378,426	$ 10,278		$ 10,278	$ 0	$ 11,992	34

**Improvement type must be detailed in order for the cost report to be considered complete.

y

To Print this page onl

Facility Name & ID Numbe COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

Hold down Control Key and hit L

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 378,426	$ 10,278		$ 10,278	$	$ 11,992	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 378,426	$ 10,278		$ 10,278	$ 0	$ 11,992	34

**Improvement type must be detailed in order for the cost report to be considered complete.

y

Facility Name & ID Numbe COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		378,426	10,278		10,278		11,992	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 378,426	$ 10,278		$ 10,278	$ 0	$ 11,992	34

**Improvement type must be detailed in order for the cost report to be considered complete.

To Print this page onl

Hold down Control Key and hit j

y

Facility Name & ID Number COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 0	$ 0	$ 0	$		$ 5,222	71
72	Current Year Purchases	65,819	4,723	4,723				72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 65,819	$ 4,723	$ 4,723	$		$ 5,222	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 444,245	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 15,001	82
83	Straight Line Depreciation	(line 70, col.7 + line 75 ,col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,001	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 17,214	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease ProCare, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [xx] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1972	73	11/1/00	$ 246,500	10	10	3
4	Additions							4
5								5
6								6
7	TOTAL		73		$ 246,500 **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____
This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [xx] YES [ ] NO Terms: 1,550,000 at end of 10 years *

10. Effective dates of current rental agreement:
Beginning 11/01/00
Ending 11/01/10

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2001	$ 246,500
13.	12/31/2002	$ 246,500
14.	12/31/2003	$ 246,500

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipm $ 18,491 Description: pager, computer equipment, copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		0		
3	Classroom Wages (a)		11		11
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		0		
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 11	$	$ 11
10	SUM OF line 9, col. 1 and 2 (e)	$ 11			

C. CONTRACTUAL INCOME

In the box below record the amount of income y
facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

our
ies.

Facility Name & ID Number COTILLION RIDGE NURSING HOME # 0045138 Report Period Beginning: 1/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Cost	Outside Practitioner (other than consultant) Units	Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs		$		$ 25,300	$		$ 25,300	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs				2,683			2,683	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a/3	hrs				63,334			63,334	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39/3	# of prescrpts					44,985		44,985	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): Lab / X-ray	39/3					5,751			5,751	13
14	TOTAL				$		$ 97,068	$ 44,985		$ 142,053	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview